State of West Virginia ★ Public Employees Insurance Agency
Retirement Health Benefits and Basic Life Insurance Enrollment Form

RET

Please read and follow the instructions on the back of this form when completing it. Use this form to enroll for PEIA health and basic life insurance coverage as a retiree. You **must** complete this form to continue your benefits as a retiree. Complete all sections of the form except the last section, "AGENCY", and return the completed form to your benefit coordinator.

RETIREE

Name (Last) (First) (MI)	Generation: (Jr., Sr., etc)	Social Security Number	Medicare ID Number
Street Address	County of Residence	Home Phone ( )	
City	State / Zip	Work Phone ( )	
Date of Birth (mm/dd/yyyy)	Sex (Check One) ☐ M ☐ F	I decline participation in any health or life insurance coverage. Signature / Date	

FAMILY INFORMATION

1) Were you recently covered by any health benefits plan for a period of at least three (3) months? ☐ Yes ☐ No

Plan Name_____ Termination Date:_____

2) Provide the date when you were or when you will be entitled to Medicare coverage. Effective Date:_____

3) Complete the following information for all dependents who will be covered under your plan. (Include Medicare under Other Insurance)

Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)		Sex/Category (see instruction on back of form)	Birth Date (mm/dd/yyyy)	Social Security Number	Other Insurance (Plan Name)
		SP	**CH**				
		SP	**CH**				
		SP	**CH**				

BASIC LIFE BENEFICIARY

Beneficiary Name (Last, First, MI, Generation)	Beneficiary Address (Street, City, State, Zip)	Social Security Number	Relationship to the Insured	Distribution % (Total Must Equal 100%)

COVERAGE

COVERAGE SELECTION (Select One)
I am enrolling for:

☐ Policyholder Only Health and Life (specify plan) _____

☐ Family Health and Life (specify plan) _____

☐ Life Insurance Only (NO health benefits)

☐ Life Insurance Only (health benefits under spouse's PEIA plan)

EARNED EXTENDED BENEFITS
(Sick and/or Annual Leave Credits)

Complete if you have sick and/or annual leave credits. I choose to use my credits to:

☐ Extend my employer-paid insurance coverage
Please be aware that if the policyholder dies while using this benefit, survivors may continue coverage, but may not use any remaining accrued leave.

☐ Increase my annuity amount (Complete proper forms from CPRB)

DEDUCTION AUTHORITY

☐ I authorize annuity deduction for any required premium beginning immediately after my earned extended coverage ends.

☐ I authorize annuity deduction for any required premium. I am not using leave credit for insurance.

☐ I DO NOT authorize annuity deductions. I request that my coverage terminate at the end of my earned extended coverage.

AFFIDAVIT

Tobacco Affidavit

Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your PEIA coverage uses tobacco, you will receive a discount on your PEIA PPB Plan health coverage (if any) and optional life insurance premiums. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ No Tobacco Users within the last six (6) months

ACCEPTANCE

I hereby accept the group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the choices I have made may affect my contributions. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the health care plan I have selected, of all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.

Signature: Date:

To Be Completed By The Employer:

AGENCY

Agency Name	Active Account Number	Retiree Account Number	Coverage Code
Last Date of Active Employment	Effective Date of Retirement	Effective Date of Retiree Insurance Coverage	

Number of days of accrued sick and annual leave for which the employee was not paid when employment ceased:	Number of months of earned extended insurance coverage (2 days = 1 month single; 3 days = 1 month family coverage) Partial months are not allowed.	Higher Education Extension (FACULTY ONLY) 3-1/3 years service = 1 year single coverage 5 years service = 1 year family coverage Total years of extended coverage (in months):	Total WV State Government credited years of service:

I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: Date:

WHITE - PEIA GREEN - Managed Care CANARY - Payroll Location PINK - CPRB GOLDENROD - Employee

Instructions for Retirement Health Benefits and Basic Life Insurance Enrollment Form

Please follow these instructions carefully when completing this form.

RETIREE

Complete ALL demographic information. The "Generation" area provides a space for men to indicate family generation indicators such as Jr., Sr., II, III, IV, etc.

If you ***do not*** wish to enroll for health or life insurance coverage as a retiree, sign and date the box stating "I decline participation ..." and return the form to your benefit coordinator.

FAMILY INFORMATION

1) Please give us information about health insurance that you had during the last three months of your active employment.

If you are currently in the PEIA PPB Plan or one of the managed care plans offered by PEIA, please write in the name of the plan you're in; you do not need to include a termination date.

If you had coverage from another insurer, in the space provided, please write in the plan name and termination date, and attach a certificate of creditable coverage from the other insurer to this form.

2) We need information about Medicare coverage for you. Please provide us your Medicare Claim Number, which is listed below your name on your red, white and blue colored Medicare card. It is a ten digit number followed by an alpha character; be sure to include the letter that follows the number. Please write this number on the reverse of this page in the box in the upper right corner titled Medicare ID Number.

3) We need to know about any dependents to be covered under your health insurance. Please complete the chart. In column titled "Sex/Category", include gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). The relationship codes are:

1. Child (biological or adopted)
2. Step-child
3. Grandchild
4. Court-Ordered Dependent Child
5. Student (age19-25)
6. 0ther

If adding a dependent child other than your biological or adopted child, notarized documentation is required showing that the child is completely dependent upon the policyholder for financial support.

BENEFICIARY

Your health insurance includes a basic decreasing term life insurance policy on you. Please designate the beneficiary(s) of this basic term life insurance policy in the "Basic Life Insurance Beneficiary" section. Please consult your insurance coordinator if you have questions about the amount of life insurance coverage you have. The life insurance proceeds will be distributed equally among all designated beneficiaries unless you specify otherwise on this form. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who dies before the policyholder will be distributed equally among all surviving named beneficiaries. If no beneficiary survives the employee, payment will be made in accordance with the terms of the policy. The name of the beneficiary should be written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe."

COVERAGE

Coverage Selection: Please indicate the type of coverage you choose to have in retirement. Remember that if you are continuing your health care coverage into retirement, you must remain the health care plan you were in as an active employee through the end of the plan year (June 30), unless you were in a managed care plan and will be Medicare-eligible when you retire. Please be sure to fully specify the plan you want, including the plan name and any option, such as PEIA PPB Plan A or The Health Plan Plan B. For life insurance, on this form, you can continue your basic life insurance. If you wish to continue Optional and/or Dependent coverage, you must complete the Retiree Optional Life Insurance form.

Earned Extended Benefits: If you have sick and/or annual leave credits, you must specify how you want to use those credits. You may use them to extend your employer-paid coverage under PEIA or to increase your annuity from CPRB. If you have been in the Plan since before July 1, 1988, your accrued leave days will pay 100% of your monthly premium. If you came into the Plan after July 1, 1988, but before July 1, 2001, your accrued leave days will pay 50% of your monthly premium. For details, please see your Summary Plan Description. If you were hired after July 1, 2001, you cannot use sick/annual leave credits to extend employer-paid insurance coverage.

Deduction Authority: Please indicate how you will pay your premiums by checking the appropriate box.

AFFIDAVIT

PEIA offers discounts to tobacco-free plan members for both health and optional life insurance. You must complete the affidavit to qualify for the discounts.

ACCEPTANCE

When you have made your selections on this form, you must sign and date the "Acceptance" box.

COMPLETING THE PROCESS

When your form is complete, return it to the benefit coordinator at your place of employment (or to the Consolidated Public Retirement Board, if you are already retired). Your benefit coordinator will complete the Agency portion of the form and submit it for processing.